April 14, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0738-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. This physician is board certified in anesthesiology. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a female who sustained a work related injury on ___. The patient reported feeling back pain after falling. The patient underwent a lumbar laminectomy on 8/7/02. The patient was noted to be experiencing significant pain behavior, depression and anxiety secondary to her chronic pain, sleep deprivation and post laminectomy syndrome. The patient has also undergone IDET and 2 fluoroscopically guided epidural steroid injections. The patient has been treated with oral pain medications and antidepressants.

Requested Services

Psychiatric evaluation.

Decision

The Carrier's denial of authorization for the requested services is overturned.

Rationale/Basis for Decision

The ___ physician reviewer noted that the patient sustained a work related injury on ___. The ___ physician reviewer also noted that the patient underwent evaluation and received conservative therapy followed eventually by surgical intervention undergoing a lumbar laminectomy on 8/7/02. The ___ physician reviewer explained that the patient has continued with back pain/post laminectomy syndrome. The ___ physician reviewer noted that the patient has undergone further procedures including intradiscal electothermal therapy, discogram under fluoroscopy, physical therapy and epidural steroid injection therapy times 2. The ___ physician reviewer explained that the patient has continued with back pain associated with depression, anxiety and insomnia. The ___ physician reviewer indicated that the patient has been treated with antidepressant medication in addition to analgesic therapy without complete relief of her chronic pain syndrome. The ___ physician reviewer explained that the patient has a significant pain syndrome that is associated with both psychological factors and general medical condition. The ___ physician reviewer also explained that the patient has been treated with appropriate medical therapy and continues to have significant pain associated with depression, anxiety and insomnia. The ___ physician reviewer noted that the treating pain management specialist feels the patient has received and failed multiple medical and interventional therapies. The ___ physician reviewer explained that a psychiatric evaluation would be most appropriate to evaluate the members potential for success in such a program. The ___ physician reviewer also explained that the patient chronic pain condition warrants therapy in a comprehensive pain management program to insure the greatest potential for long-term pain relief. The ___ physician reviewer further explained that a review of the medical records provided indicated the requested psychiatric evaluation is medically necessary for treatment of this enrollee's chronic pain syndrome. Therefore, the ___ physician consultant concluded that the requested psychiatric evaluation is medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 14th day of April 2003.